LOUISIANA DEPARTMENT OF INSURANCE
Office of Health Insurance
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PROVIDER PROMPT PAYMENT MULTIPLE CLAIM COMPLAINT FORM

INSTRUCTIONS

NOTICE: THIS COMPLAINT FORM CAN ONLY BE FILED ELECTRONICALLY.

PURPOSE:

This is a limited purpose complaint form designed for health care providers who provide services under contract with Health Insurance Issuers for the following types of coverage:

- Major Medical Insurance
- Health Maintenance Organization Subscriber Agreements (HMO)

The purpose of this form is to collect claim samples from providers to document that health insurance issuers are not paying claims timely or not paying claims in accordance with Part VI-D of Chapter 1 of Title 22 of the Louisiana Revised Statutes of 1950.

FORM COMPLETION INSTRUCTIONS:

General Instructions

- The complaint form is to be used to identify and document violations of a specific violation listed under Part II of the form and supported by an attached claim. **We cannot accept multiple violations on a single complaint form.** A separate complaint form and claim data sheet **must** be filed for each specific problem to document the violation. The MPPC-05 can be used for claims filed Electronically (E), Non-Electronically (N) and for insurers who use a 30-day payment standard (T). This form should be used when filing six (6) or more complaints against one health insurance insurer.

- Providers are to complete all fields that are in "Green", with any comments typed in green. Insures are to complete all fields that are in "Red", with any comments typed in red. Once all fields are completed, the fields in "Black" will automatically be computed.

- Determine that each claim being submitted was filed with the health insurance issuer within the time period provided under your contract. You may be required to provide proof of timely filing to dispute a health insurance issuer's finding that a claim was not filed or filed after the contractual time period. The following types of documentation will be accepted by the Department in support of a dispute regarding receipt or date of receipt of a claim:

  1. A copy of the carrier's clearinghouse electronic confirmation to your clearinghouse. If your clearinghouse advises they do not perform this service, you may wish to utilize a clearinghouse that performs this service. If your clearinghouse advises that the carrier refuses to confirm receipt of electronic claim filings, please provide evidence in the form of a letter of denial from the carrier or an affidavit from the clearinghouse.

2. When submitting a complaint form for non electronic filing, include a batch claim report containing all claims run for that report and then highlight the claims which have been paid. DOI will request documentation from the health insurance issuer of claims that have been paid from this batch.

3. For non-electronic filings, batch claim reports that identify other claims shown on the complaint form that the carrier advises were received and adjudicated during the investigation.

4. A copy of any delivery receipt that documents the claim was delivered to the health insurance issuer. Please note, the receipt must have a written reference to either the specific claim or the batch of claims that were delivered.

- Reconcile all remittance advices with your billing system to assure the problem is not a posting error.

- Review any other correspondence from the health insurance issuer to verify additional information was not requested.

- Determine whether "just and reasonable grounds such as would put a reasonable and prudent businessman on his guard" exist on a claim and provide explanations obtained from the insurance company or HMO. Examples of "just and reasonable grounds" include, but are not limited to:

    - Investigation of a pre-existing condition or possible contestable contract;
    - Questionable eligibility of coverage for dependents required to be full time students;
    - Coordination of benefits where there is reasonable grounds to believe other coverage is in effect;
    - Submission of the explanation of benefits paid by a primary carrier.

  If the complaint being filed is about unreasonable requests for information, document these claims by spreadsheet row number on the complaint form in the space provided for this type of complaint.

Specific Form Instructions:

Part I

Complete this part of the complaint form as indicated.

Part II

Due to the amount of time necessary to conduct an investigation, each complaint must be filed under a category listed below and submitted as a separate complaint for each type of problem. Each complaint filed is limited to a single problem with a single insurer.

"**Claims are not paid timely**"- check this box if the health insurance issuer is paying claims after the statutory timeframes and not paying late payment fees or the fees paid are not accurate. If you are not sure if late payment fees are calculated accurately, use the spreadsheet to load your data and compare the amount shown with the amount paid by the health insurance issuer.

"**Claims not received, then denied for non-timely filing**"- check this box if the claims were submitted and then you were told by the health insurance issuer that no claim was received. Upon refilling the claim, you were denied for filing after the filing period contained in your provider contract.

"**Claims rejected, then denied for non-timely filing**"- check this box if claims were returned for additional information or returned as incomplete. Upon resubmittal, the claims were denied for timely filing.

"Unreasonable requests for medical information"- check this box if the claims were not paid or delayed based on unreasonable requests for additional information. Please note, not all requests for additional information are unreasonable. The following examples should be followed:

Unreasonable Requests	Reasonable Requests
Requiring medical records for all ER claims	Requiring medical records for multiple days of ER claims
Requiring medical information for authorized care	Requiring medical information on unauthorized care
Requiring COB forms for all care	Requiring COB forms when claim shows other coverage

"Unreasonable COB inquiry" – check this box if claims for multiple patients (20 or more different patients, not claims or family members) are not being paid or delayed based on requests for information on other insurance coverage.

"Denial for authorization when authorized" – check this box if claims were not paid or delayed based on non-authorization when an authorization number was issued.

"Audit of claim after allowed period" – check this box if claims are being audited after the allowed period prescribed by Regulations 49 and 74. Generally, the insurer must give notice of audit within the same period of time you are allowed to file a claim. If you are allowed 90 days to file the claim, the insurer has 90 days to give notice of audit after the claim was paid.
"Recoupment of payment without notice" – check this box if claims are not being paid or delayed based on recoupment when no notice has been given.

Other (Explain below) – check this box if claims are not being paid or delayed based on a specific practice that you believe is a violation of insurance law. Please be specific in explaining the violation and the statutory requirement being violated. Disputes on the amount you are being paid under a provider contract must be resolved under the terms of your contract or through the complaint process insurers are required to follow for providers. We will investigate any refusal to abide by the arbitration decision or provider hearing ruling after you have completed the insurer's complaint process.

Completing a data sheet

The Provider Prompt Payment Multiple Claim Spreadsheet (MPPC-05) performs calculations on claims data based on claim payment standards. The correct data must be entered to correctly compute interest due.

The following is a list of errors codes that may appear if incorrect data is entered on the spreadsheet:

- 1—First column must be E, N, or T.
- 2—Payment exceeds amount due.
- 3—Claim submitted date before service date.
- 4—Payment date before Claim submitted date.
- 5—At least one date is missing.

Filing a complaint

- Send us an e-mail to the following address:
  TO: Cheryl Gordon at cgordon@ldi.state.la.us
  FROM: The e-mail address that we will use to advise of the status of your complaint.
  RE: Electronic Provider Complaint Request
  Attach one completed complaint form (MPPC)
  Attach one data sheet (MPPC-30, MPPC-45, or MPPC-25)

- Within 5 days of filing, you should receive an acknowledgement letter stating your file number and the name of the compliance examiner in charge of investigating your complaint.

- An investigation usually takes about 8 – 10 weeks, depending upon the type of violation and accuracy of information provided to us.

- A copy of your complaint will be sent with an electronic cover letter from your examiner asking for explanations from the insurance company or HMO.

- Your examiner will review all responses received to assure that all issues have been properly addressed. This may result in further inquiries between the examiner and you, the insurance company, HMO or other parties.

- Once the investigation is concluded, you will receive a detailed report of the examiner's findings along with copies of documentation furnished by the insurance company or HMO.